

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2158

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02148
Reg. Dist.

No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Md.		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Marumsco				TOWN Marumsco			
HOSPITAL OR INSTITUTION OR STREET ADDRESS En route hospital, Crisfield				STREET ADDRESS (If rural, give location) Rural			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) CARROLL (Middle) WARFIELD (Last) ADAMS				(Month) February (Day) 14 (Year) 19 56			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Married		Nov 8, 1903	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Gen Store		Mercantile		Crisfield, Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James H. Adams				Jennie G. Long			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Mrs. Lillian Adams, Marumsco, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>420.1</p> <p>Immediate cause (a) DUE TO</p> <p>Antecedent cause(s) (b) DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p> <p>Coronary Occlusion</p> <p>Arterio Sclerosis</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		21d. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		<p>William H. Coulbourn, M. D.</p> <p>DEPUTY MEDICAL EXAMINER</p> <p>FOR SOMERSET COUNTY, MD.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED</p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/15/56</p> <p>ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/16/56		Rehobeth ME Cemetery		Rehobeth, Maryland	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS					
2/15/56		<p>REGISTRAR'S SIGNATURE</p> <p>Henry H. Watson, Pocomoke, Md.</p>					

RECEIVED

FEB 20 1956

BUREAU V. S.

INSTRUCTIONS

1 executed within 24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02149

2159 CERTIFICATE OF DEATH

Reg. Dist. No. 7-65

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> LENGTH OF STAY (in this place) <u>2 Wks.</u> TOWN <u>Crisfield</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>McCready Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> TOWN <u>Crisfield</u> STREET ADDRESS (If rural give location) <u>39</u>			
3. NAME OF DECEASED (Type or Print) <u>Joseph J. Byrd</u>			4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>8</u> (Year) <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 17, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Marion Station</u>			
13. FATHER'S NAME <u>Wm. Henry Byrd</u>			14. MOTHER'S MAIDEN NAME <u>Addie Miles</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-5787</u>		17. INFORMANT & ADDRESS <u>Della Byrd - 103 S. 4th Street Crisfield, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Uremia, Acute Dil. of Heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Int Nephritis, Chronic Myocarditis</u>				<u>about 2 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan. 21, 1956</u> , to <u>Feb. 9, 1956</u> , that I last saw the deceased alive on <u>2-9-1956</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George E. Boulton</u>		M.D. <u>Marion Sta. Md.</u>		DATE SIGNED <u>2-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 12, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury M. Lawson</u>			
24. REC'D BY REGISTRAR <u>Nellie D. Payne</u>		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Crisfield, Som. Co. Md.</u>			
DATE <u>2-11-56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>			

CERTIFICATE OF DEATH

MADE BY THE

Physician or other person authorized by the Board of Health to sign the same

Name of deceased

Age

Sex

Color

Place of birth

Usual residence

Occupation

Cause of death

BUREAU V. 2

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CERTIFICATE OF DEATH

Reg. Dist. No. 265

2155

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Somerset		MARYLAND		STATE Maryland		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) 39 TOWN Crisfield		LENGTH OF STAY (in this place) 40 years		CITY (If outside corporate limits, write RURAL and give nearest town) 39 TOWN Crisfield			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 615 W. Main St.				STREET ADDRESS (If rural give location) 615 W. Main St.			
3. NAME OF DECEASED: (First) SOL		(Middle) SAMUEL		(Last) CRANDALL		4. DATE OF DEATH: (Month) February (Day) 2 (Year) 1956	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: April 15, 1881	
9. AGE last birthday: 74 yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Owner		11. BIRTHPLACE (State or foreign country): Minsk, Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No.: 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No	
17. INFORMANT & ADDRESS: 615 W. Main St. Mrs. Celia Crandall—Crisfield, Md.		18. MEDICAL CERTIFICATION		Interval Between Onset And Death			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		(a) Pulmonary Edema		1 hr.			
Immediate cause		DUE TO		2 hrs.			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) Hypertensive Heart Disease					
		DUE TO					
		(c) Hypertension					
11. OTHER SIGNIFICANT CONDITIONS		19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Conditions contributing to the death but not related to the disease or condition causing death.							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
m.							
22. I hereby certify that I attended the deceased from Jan. 2, 1956, to Feb. 2, 1956, that I last saw the deceased alive on Feb. 1, 1956, and that death occurred at 1 a.m., from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
David M. Peyton		Feb. 3, 1956		Jewish Cemetery—New York City		New York City, N. Y.	
23. BURIAL, CREMATION, REMOVAL (Specify)		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Burial		Barbara S. Adams		Bradshaw & Sons—Crisfield, Md.			
DATE REC'D BY LOCAL REGISTRAR							
2/2/56							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 6 1956

BUREAU V. S.

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INSTRUCTIONS

1 executed within **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2156 **CERTIFICATE OF DEATH**

02151

Reg. Dist. No. 265

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Somerset		STATE Maryland		COUNTY Somerset			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield		LENGTH OF STAY (in this place) lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crandall Apts. Chesapeake Ave.		STREET ADDRESS Crandall Apts. Chesapeake Ave.		(If rural, give location)			
3. NAME OF DECEASED (Type or Print) EDNA NELSON CULLEN				4. DATE OF DEATH (Month) February (Day) 14 (Year) 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Feb. 10, 1908	9. AGE last birthday 48 yrs.	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tomato packing		10b. KIND OF BUSINESS OR INDUSTRY Canning Industry		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Nelson				14. MOTHER'S MAIDEN NAME Nola Riffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Maryland Ave. Mrs. Paul Sterling-Crisfield, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Carcinoma of Cervix C						INTERVAL BETWEEN ONSET AND DEATH 4 yrs -	
ANTECEDENT CAUSE(S) DUE TO (B) Metastases to intestines etc.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1954		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Cervix		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 18, 1955</u>, to <u>Feb. 14, 1956</u>, that I last saw the deceased alive on <u>Feb. 14, 1956</u>, and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE Dorothy M. Peyton				DATE SIGNED 33 W. Main - Crisfield, Md. 2/16/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 17, 1956		NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		LOCATION (City, town, or county) (State) Marion Station, Md.	
24. REC'D BY REGISTRAR DATE 2/16/56		REGISTRAR'S SIGNATURE Barbara L. Adams		25. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons-Crisfield, Md.			

CERTIFICATE OF DEATH

BUREAU A. S.

FEB 20 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 12M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02152

2157 CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Somerset		STATE Maryland		COUNTY Somerset			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crisfield		lifetime		TOWN Crisfield			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 316 Chesapeake Ave.				STREET ADDRESS (If rural give location) 316 Chesapeake Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
CARLTON (First) ORIS (Middle) DIZE (Last)				February 3, 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	July 5, 1887	68 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Barber		For Himself		Crisfield, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
McClelland Dize				Arintha Dize			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Cove St. Harvey Dize— Crisfield, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						few minutes	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						9 mo.	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 19 56, to Feb. 3, 19 56, that I last saw the deceased alive on Jan. 30, 19 56, and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
A. N. Ban				Crisfield, Maryland		2/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				Feb. 5, 1956		Sunnyridge Cemetery	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE				Bradshaw & Sons—Crisfield, Md.		ADDRESS	
7/10/56				Barbara S. Adams			

BUREAU V. S.

RECEIVED

2160

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
✓ b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crissfield-Som.Co.</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edward McCready Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>T.</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Marion Sta., Som.Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George Hickman</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Ward</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances Hickman-1711 S. St. Phila., Pa.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Acute Dil.</u> DUE TO <u>of Heart -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis -</u> DUE TO <u>Hypertension</u> (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>2 yrs</u> <u>3 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 13, 1956</u> , to <u>Feb 27, 1956</u> , that I last saw the deceased alive on <u>Feb 27, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Cullbourn</u> M.D.		ADDRESS (Street, city or town, state) <u>Marion Station</u> DATE SIGNED <u>2-29-56</u>	
PHYSICIAN'S NAME (Type) <u>George C. Cullbourn</u>		MD. <u>Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodward Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som.Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Station, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-29-56</u> 24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 13 1966
COLUMBIA U. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 260

2161

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rumblay				c. LENGTH OF STAY IN 1b 60 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Aubrey Holland				4. DATE OF DEATH Month Day Year Feb. 24 1956			
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1886		9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman			10b. KIND OF BUSINESS OR INDUSTRY waterman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Holland				14. MOTHER'S MAIDEN NAME Emma Daugherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs Ida Holland Rumblay, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Breast DUE TO (c) Primary Carcinoma of Lung							INTERVAL BETWEEN ONSET AND DEATH Four months 9 mo. 13 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1955, to Feb 24 1956, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED G. N. Barr M.D. Crisfield, Md. 2/25/56							
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-26-1956	22c. NAME OF CEMETERY OR CREMATORY Fairmount cemetery		22d. LOCATION (City, town, or county) (State) Fairmount, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE 2/28/56	24b. REGISTRAR'S SIGNATURE R. D. Johnson, M.D.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

MAR 1 1956

RECEIVED

2162

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. LENGTH OF STAY IN 1b <u>BOX 100</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>00 H. F. D. I BOX 100</u>		d. STREET ADDRESS <u>Princess Anne R 701 100</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Fletcher</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Calred</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1888</u>
9. AGE (in years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Jones</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-28-8291</u>	
17. INFORMANT <u>Charles Jones Princess Anne Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>12222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 27</u> , 19 <u>56</u> , to <u>Feb 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>56</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldon G. Marksmann</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Princess Anne Md</u> <u>3/2/56</u>	
PHYSICIAN'S NAME (Type) <u>Eldon G. Marksmann</u>		<u>Princess Anne, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-4-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis R. Wilson</u>		ADDRESS <u>Princess Anne Md</u>	
24. REC'D BY REGISTRAR DATE <u>3/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>L. R. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5

RECEIVED

2163 CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Princess Anne</u>				TOWN <u>Princess Anne</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.</u>				STREET ADDRESS (If rural give location) <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>H.</u> (Last) <u>Jones</u>				(Month) <u>Feb.</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>male</u>	<u>colored</u>	<u>married</u>	<u>Sept. 12, 1892</u>	<u>63</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>farmer</u>		<u>farmer</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Martin Jones</u>				<u>Ella Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mrs Capitola Jones Pr. Anne, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>18 mths</u>	
IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 15, 1954</u> , to <u>Feb 5, 1956</u> , that I last saw the deceased alive on <u>Jan 31, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eldon G. Montman</u>				ADDRESS (Street, city, town, state) <u>Princess Anne, Md.</u>			
DATE SIGNED <u>2-8-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>2-8-1956</u>		<u>St. Paul Cemetery</u>		<u>Mt. Vernon, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2/10/56</u>		<u>R. S. Johnson, M.D.</u>		<u>Levin R. Wilson, Pr. Anne, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

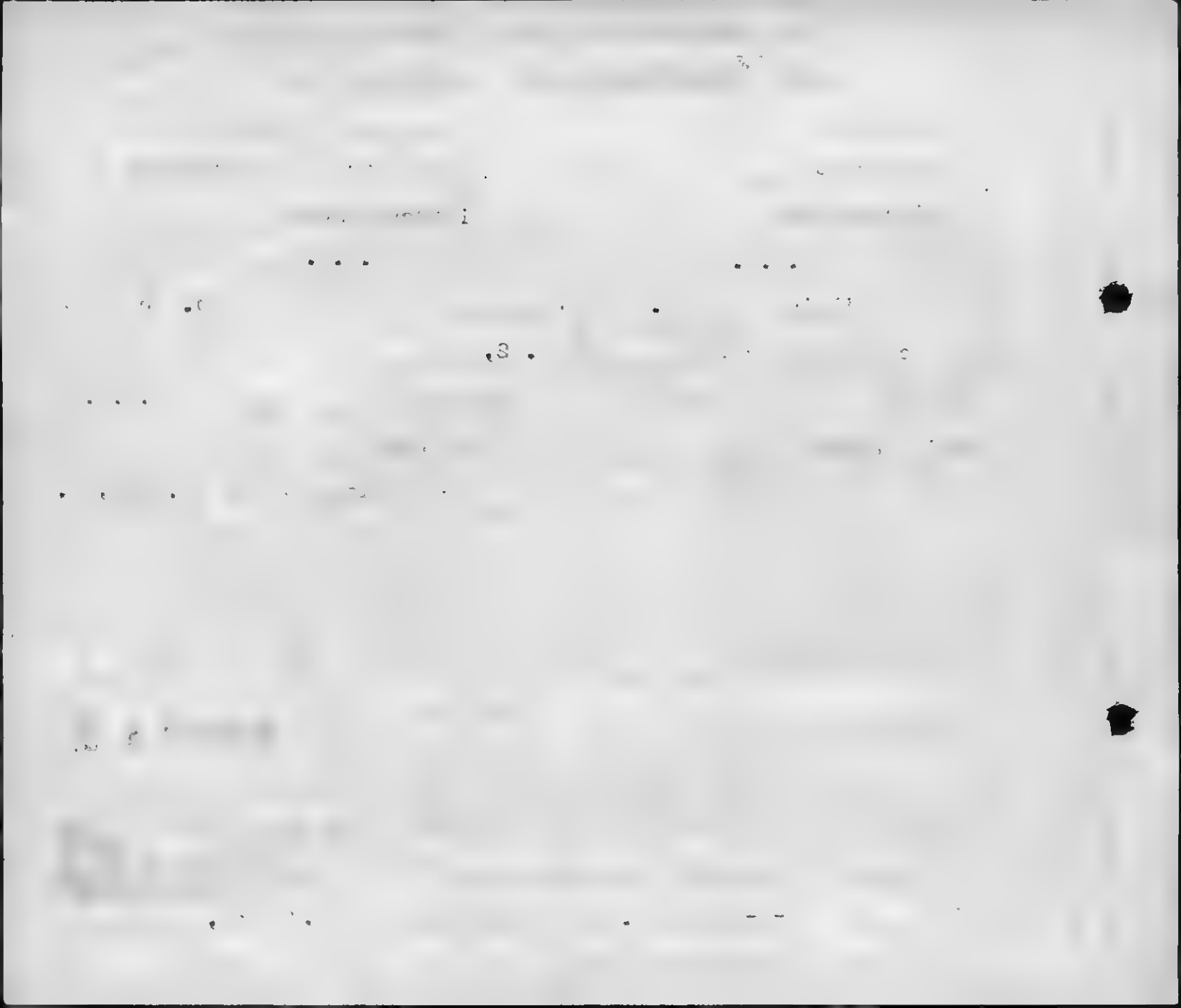
VS AISC 1-55 10M

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2164

CERTIFICATE OF DEATH

02157

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 79 McCready Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last EDWARD TRAVIS LONDON				4. DATE OF DEATH Month Day Year February 20 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1872		9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Fairmount, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Wesley Landon				14. MOTHER'S MAIDEN NAME Margaret Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-32-0626		17. INFORMANT Address Mrs. Elizabeth M. Landon-Marion Station, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, Acute Dil of heart</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Infarction</u> DUE TO (c) <u>Chronic Myocarditis, Chronic Dil</u>						INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 72 hrs. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>At intervals</u> 19 <u>54</u> to <u>Feb. 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>56</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George C. Coulbourne</u> M.D.				ADDRESS (Street, city or town, state) Marion Station, Md.		DATE SIGNED 2-21-56	
PHYSICIAN'S NAME (Type) George C. Coulbourne, M.D.				Marion Station, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		22d. LOCATION (City, town, or county) (State) Fairmount, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons—Crisfield, Maryland				24a. REC'D BY REGISTRAR DATE 2-21-56		24b. REGISTRAR'S SIGNATURE <u>Willie R. Payne</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02159

2165

CERTIFICATE OF DEATH

Reg. Dist. No. 360.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Somerset</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Princess Anne</u>		LENGTH OF STAY (in this place) <u>6 mon.</u>		CITY OR TOWN <u>Fruitland Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.</u>		STREET ADDRESS <u>Camden Ave. Ext.</u>					
3. NAME OF DECEASED (Type or Print) <u>James T. Owens</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED <u>Widowed</u>	8. DATE OF BIRTH <u>July 7, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Uriah Owens</u>				14. MOTHER'S MAIDEN NAME <u>Susan Briddell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ralph Porter, Princess Anne, R.F.D.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gen. Arteriosclerosis</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>				<u>20 yrs.</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Recent left pleurisy + Bronchitis</u>				<u>1 yr.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 1, 1955</u> to <u>FEB 27, 1956</u> that I last saw the deceased alive on <u>2-27-56</u> and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Princess Anne, Md.</u> DATE SIGNED <u>2/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Mar. 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Episcopal</u>		LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3/3/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Princess Anne, Md.</u>			

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12

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2166 CERTIFICATE OF DEATH

02160

Reg. Dist. No. *2166*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Somerset</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <i>Princess Anne</i>		<i>11 yrs</i>		TOWN <i>Princess Anne</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Phillip</i> (Middle) <i>H</i> (Last) <i>Plott</i>				(Month) <i>Feb</i> (Day) <i>23</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Dec 27 1890</i>	<i>65</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Real Estate Broker</i>		<i>Real Estate</i>		<i>New Jersey</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Isaac Hull Plott</i>				<i>Emma S. Haralson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>No</i>				<i>203-10-7358</i>		<i>Dr. George Henry Pittman, Anne</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<i>Myocardial infarction</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>CORONARY OCCLUSION</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<i>INSTANTLY</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1956</i> to <i>1956</i> , that I last saw the deceased alive on <i>Feb 23</i> , 19 <i>56</i> , and that death occurred at <i>10:05</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>Geo M. H. Plott</i>				ADDRESS (Street, city, town, state) <i>Princess Anne Md.</i>			
DATE <i>2-24-56</i>				DATE SIGNED <i>2-24-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2/26/56</i>		<i>Methodist Episcopal Church</i>		<i>Princess Anne Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>2/27/56</i>		<i>R. H. Plott</i>		<i>James L. Plott</i>		<i>Princess Anne Md.</i>	

RECEIVED

FEB 09 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate must be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate must be detached for use as a burial transit permit.

VS A15 1-55 701

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02161

2167 CERTIFICATE OF DEATH

Item 9, Film G193 2-29-56 et

Reg. Dist. No. 261

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Somerset</u>	STATE <u>Md.</u>	COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rehoboth</u>	LENGTH OF STAY (In this place) <u>6 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rehoboth</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Charlie</u> (Middle) <u>Robinson</u> (Last)		(Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 25, 1903</u>
9. AGE last birthday <u>52 5/8</u> yrs.		10. IF UNDER 1 YEAR (Month) (Day) (Year)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Maria Waters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Sarah Waters-Recomoke Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>myocardial Condition</u>		<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>(Found dead in bed)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>myocarditis, Nephritis,</u>		<u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General Arteriosclerosis</u>		<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 16, 1956</u> , to <u>Feb. 17, 1956</u> , that I last saw the deceased alive on <u>Feb. 16, 1956</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>George G. Gorman</u> M.D.		DATE SIGNED <u>2-20-56</u>	
ADDRESS (Street, city, town, state) <u>Marion Sta. Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/21/56</u>	NAME OF CEMETERY OR CREMATORY <u>Ward's Memorial</u>	LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co. Md.</u>
24. REC'D BY REGISTRAR <u>Nellie D. Payne</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>	ADDRESS <u>Marion Sta., Md.</u>

Box 235.

U. S. A.

1956 3 13

RECEIVED

2168 CERTIFICATE OF DEATH

02163

Reg. Dist. No. 2168

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Somerset		STATE Maryland		COUNTY Somerset			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Fairmount		lifetime		TOWN Fairmount			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ELSIE BOGGS WATERS				February 15 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Female	Colored	Widowed	May 13, 1889	66 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Seafood Laborer		Seafood Industry		Fairmount, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Wimore Boggs				Eliza Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		215-14-6915		Box 53 Theodore F. Waters--Lower Fairmount, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)		Constrictive Heart Failure					5 yrs.
ANTECEDENT CAUSE(S) DUE TO (B)		Essential Hypertension					6 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Dehydration					1 month
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 19 55 to Feb 19 56, that I last saw the deceased alive on 2/4/1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Paul A. Downey M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 19, 1956		Centennial Church Cemetery		Fairmount, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
				Bradshaw & Sons--Crisfield, Maryland			
DATE							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. V. 3

17 AUG 1961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2169

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02164
Reg. Dist.

No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rural Pocomoke</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Pocomoke R.F.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>E</u> (Last) <u>Waters</u>				(Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>Aug 5 - 1876</u>	
9. AGE last birthday: <u>79</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>				10b. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
13. FATHER'S NAME: <u>Nathaniel Ward</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Self</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>Mary Waters Jr. - Pocomoke R.F.D.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Senility and debility -</u>						<u>several</u>	
DUE TO						<u>years -</u>	
Antecedent cause(s) (b) <u>Long patient after death</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (c) <u>stating underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb 3 - 56</u>					
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.					
M. D.							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>2/4/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Trinity Chapel - Pocomoke, Md.</u>		LOCATION (City, town, or county) (State): <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/3/56</u>		REGISTRAR'S SIGNATURE: <u>R. S. Johnson, Jr.</u>		24. FUNERAL DIRECTOR: <u>Edgar Roberts</u>		ADDRESS: <u>New Church, Md.</u>	

BUREAU V. S.

FEB 8 1936

RECEIVED

2170

CERTIFICATE OF DEATH

Reg. Dist. No. - 261-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Route 1, Marion</u>	<u>18 yrs.</u>	<u>Route 1, Marion</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Helen Emma Whittington</u>		<u>Feb. 12 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>Negro</u>	<u>married</u>	<u>Sept. 29, 1887</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>68 yrs.</u>		<u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<u>United States</u>		<u>United States</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Harme Whittington</u>		<u>Jenny Whittington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>215-18-4359</u>	
17. INFORMANT'S ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Angela Whittington-Marion-Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		420.1 IMMEDIATE CAUSE (A) <u>Coronary Condition</u>	
		ANTECEDENT CAUSE (B) <u>Chronic Myocarditis + Nephritis</u>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>General Arteriosclerosis</u>	
		<u>Cardiovascular asthma</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 11, 1956</u> , to <u>Feb. 12, 1956</u> , that I last saw the deceased alive on <u>Feb. 11, 1956</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>George E. Corbellum</u>		DATE SIGNED <u>Feb 12 1956</u>	
M. D. <u>Marion Sta. Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATION	
<u>Burial</u>		<u>Family Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>2-13-56</u>		<u>Marion, Somerset, Md.</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Nellie D. Payne</u>		<u>George W. Telghoran</u>	
		ADDRESS	
		<u>Marion Md</u>	

RECEIVED

FEB 20 1956

BUREAU V. S.